FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038349

Facility Name: HERITAGE MANOR-BLOOMINGTON

Address: 700 E. WALNUT (Number) BLOOMINGTON (City) 61701 (Zip Code)

County: MCLEAN

Telephone Number: (309)827-8004 **Fax #** ( )

IDPA ID Number: 370909086003

Date of Initial License for Current Owners: 1963

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CRAIG L. ATER **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) CRAIG L. ATER

(Title) SENIOR V.P. FINANCE

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	111	Skilled (SNF)	111	40,515	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	111	TOTALS	111	40,515	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,847	11,435	2,469	36,751	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	22,847	11,435	2,469	36,751	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.71%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? ____

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1963

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 2,469

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

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	G/L	RECAP CENSUS	DIFF
PP	12733	12733	0
IPA	22996	22996	0
medicare	2469	2469	0
	38198	38198	

IPA BEDHOLDS	149
PP BEDHOLDS	100
PP CONVERS	1198

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	245,762	22,966	0	268,728		268,728	3,431	272,159			1
2	Food Purchase		170,137		170,137		170,137	(857)	169,280			2
3	Housekeeping	66,314	23,386		89,700		89,700	0	89,700			3
4	Laundry	50,862	15,555		66,417		66,417	0	66,417			4
5	Heat and Other Utilities			106,960	106,960		106,960	1,397	108,357			5
6	Maintenance	111,061	46,669	48,183	205,913		205,913	11,006	216,919			6
7	Other (specify):*							0				7
8	TOTAL General Services	473,999	278,713	155,143	907,855		907,855	14,977	922,832			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	0	12,000			9
10	Nursing and Medical Records	1,447,854	71,028	11,396	1,530,278		1,530,278	0	1,530,278			10
10a	Therapy		218,180	205,622	423,802	(384,246)	39,556	137,629	177,185			10a
11	Activities	61,494	1,670	0	63,164		63,164	0	63,164			11
12	Social Services	27,988	4	2,305	30,297		30,297	0	30,297			12
13	Nurse Aide Training	13,304	900		14,204		14,204	2,051	16,255			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16		1,550,640	291,782	231,323	2,073,745	(384,246)	1,689,499	139,680	1,829,179			16
	C. General Administration											
17	Administrative	58,397			58,397		58,397	30,413	88,810			17
18	Directors Fees							4,763	4,763			18
19	Professional Services			287,996	287,996		287,996	(266,910)	21,086			19
20	Dues, Fees, Subscriptions & Promotions			87,586	87,586	(60,773)	26,813	(8,848)	17,965			20
21	Clerical & General Office Expenses	107,580	14,220	8,857	130,657		130,657	165,136	295,793			21
22	Employee Benefits & Payroll Taxes			368,226	368,226		368,226	23,440	391,666			22
23	Inservice Training & Education			728	728		728	900	1,628			23
24	Travel and Seminar			4,796	4,796		4,796	(2,797)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			26,428	26,428		26,428	1,686	28,114			26
27	Other (specify):*			19,517	19,517		19,517	(19,517)				27
28	TOTAL General Administration	165,977	14,220	804,134	984,331	(60,773)	923,558	(71,734)	851,824			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,190,616	584,715	1,190,600	3,965,931	(445,019)	3,520,912	82,923	3,603,835			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			181,823	181,823		181,823	6,721	188,544			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			184,399	184,399		184,399	(502)	183,897			32
33	Real Estate Taxes			61,221	61,221		61,221	0	61,221			33
34	Rent-Facility & Grounds							2,285	2,285			34
35	Rent-Equipment & Vehicles			3,758	3,758		3,758	15,156	18,914			35
36	Other (specify):*							0				36
37	TOTAL Ownership			431,201	431,201		431,201	23,660	454,861			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					384,246	384,246	0	384,246			39
40	Barber and Beauty Shops	0	0	16,223	16,223		16,223	0	16,223			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					60,773	60,773	0	60,773			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers			16,223	16,223	445,019	461,242		461,242			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,190,616	584,715	1,638,024	4,413,355	0	4,413,355	106,583	4,519,938			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,311)	35		5
6	Rented Facility Space	(5,600)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(677)	30		9
10	Interest and Other Investment Income	(407)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(857)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	0	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(528)	20		17
18	Fines and Penalties				18
19	Entertainment	(9,191)	24		19
20	Contributions	(65)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,068)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,452)	27		24
25	Fund Raising, Advertising and Promotional	(12,809)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (53,965)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	160,548		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 160,548		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 106,583		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Print Previe

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name **HERITAGE MANOR-BLOOMINGTON**

ID# **0038349**

Report Period Beginning: **01/01/01**

Ending: **12/31/01**

Print Other Adjustment

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	(857)
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	0	0	Line 4	0
5	Telephone, TV & Radio in Resident Rooms	(1,311)	35	Line 5	0
6	Rented Facility Space	(5,600)	34	Line 6	0
7	Sale of Supplies to Non-Patients	0		Line 7	0
8	Laundry for Non-Patients	0		Line 8	(857)
9	Non-Straightline Depreciation	(677)	30	Line 9	0
10	Interest and Other Investment Income	(407)	32	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	0		Line 10a	0
12	Non-Working Officer's or Owner's Salary	0		Line 11	0
13	Sales Tax	(857)	2	Line 12	0
14	Non-Care Related Interest	0	32	Line 13	0
15	Non-Care Related Owner's Transactions	0	33	Line 14	0
16	Personal Expenses (Including Transportation)	0	24	Line 15	0
17	Non-Care Related Fees	(528)	20	Line 16	0
18	Fines and Penalties	0		Line 17	0
19	Entertainment	(9,191)	24	Line 18	0
20	Contributions	(65)	27	Line 19	(3,068)
21	Owner or Key-Man Insurance	0		Line 20	(13,337)
22	Special Legal Fees & Legal Retainers	(3,068)	19	Line 21	0
23	Malpractice Insurance for Individuals	0		Line 22	0
24	Bad Debt	(19,452)	27	Line 23	0
25	Fund Raising, Advertising and Promotional	(12,809)	20	Line 24	(9,191)
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	0	0	Line 27	(19,517)
29	Non-Paid Workers	0	0	Line 28	(45,113)
30	Donated Goods	0	0	Line 29	(45,970)
31	Amortization Expense	0	0	Line 30	(677)
32				Line 31	0
33				Line 32	(407)
34				Line 33	0
35				Line 34	(5,600)
36				Line 35	(1,311)
37				Line 36	0
38				Line 37	(7,995)
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	(53,965)
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Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
14	15	17	18	19	20	21	22	23	24	25	26	27

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,431	0	0	0	0	0	0	0	0	3,431	1
2	Food Purchase	(857)	0	0	0	0	0	0	0	0	0	0	(857)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,397	0	0	0	0	0	0	0	0	1,397	5
6	Maintenance	0	0	11,006	0	0	0	0	0	0	0	0	11,006	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(857)	0	15,834	0	0	0	0	0	0	0	0	14,977	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(24,183)		0	161,812	0	0	0	0	0	0	137,629	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	2,051	0	0	0	0	0	0	0	0	2,051	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(24,183)	2,051	0	161,812	0	0	0	0	0	0	139,680	16
	C. General Administration													
17	Administrative	0	0	30,413	0	0	0	0	0	0	0	0	30,413	17
18	Directors Fees	0	0	4,763	0	0	0	0	0	0	0	0	4,763	18
19	Professional Services	(3,068)	0	11,678	0	(275,520)	0	0	0	0	0	0	(266,910)	19
20	Fees, Subscriptions & Promotions	(13,337)	0	4,489	0	0	0	0	0	0	0	0	(8,848)	20
21	Clerical & General Office Expenses	0	0	165,136	0	0	0	0	0	0	0	0	165,136	21
22	Employee Benefits & Payroll Taxes	0	0	23,440	0	0	0	0	0	0	0	0	23,440	22
23	Inservice Training & Education	0	0	900	0	0	0	0	0	0	0	0	900	23
24	Travel and Seminar	(9,191)	0	6,394	0	0	0	0	0	0	0	0	(2,797)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,686	0	0	0	0	0	0	0	0	1,686	26
27	Other (specify):*	(19,517)	0	0	0	0	0	0	0	0	0	0	(19,517)	27
28	**TOTAL General Administration**	(45,113)	0	248,899	0	(275,520)	0	0	0	0	0	0	(71,734)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(45,970)	(24,183)	266,784	0	(113,708)	0	0	0	0	0	0	82,923	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(677)	0	0	7,398	0	0	0	0	0	0	0	6,721	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(407)	0	0	(95)	0	0	0	0	0	0	0	(502)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(5,600)	0	0	7,885	0	0	0	0	0	0	0	2,285	34
35	Rent-Equipment & Vehicles	(1,311)	0	0	16,467	0	0	0	0	0	0	0	15,156	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,995)	0	0	31,655	0	0	0	0	0	0	0	23,660	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(53,965)	(24,183)	266,784	31,655	(113,708)	0	0	0	0	0	0	106,583	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTO# 0030349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 4)	
1	V		$			$	$	1
2	V	10c	Adjustment for Related Organization	208,948	Greentree Therapy	100.00%	176,717	(24,183) 2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 208,948			$ 176,717	$ * (24,183)	14

Sum_6 -24183

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6E, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6E, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6E, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 3,431	$ 3,431	15	3431
16	V	2	Food Purchase				0		16	
17	V	3	Housekeeping				0		17	
18	V	4	Laundry				0		18	
19	V	5	Heat & Other Utilities				1,397	1,397	19	1397
20	V	6	Maintenance				11,006	11,006	20	11006
21	V	7	Other				0		21	
22	V	9	Medical Director				0		22	
23	V	10	Nursing & Medical Records				0		23	
24	V	11	Activities				0		24	
25	V	12	Social Service				0		25	
26	V	13	Nurse Aide Training				2,051	2,051	26	2051
27	V	14	Program Transportation				0		27	
28	V	15	Other				0		28	
29	V	17	Administrative				30,413	30,413	29	30413
30	V	18	Directors Fees				4,763	4,763	30	4763
31	V	19	Professional Services				11,678	11,678	31	11678
32	V	20	Fees, Subscription, Promotions				4,489	4,489	32	4489
33	V	21	Clerical & General Office Expenses				165,136	165,136	33	165136
34	V	22	Employee Benefits & Payroll Taxes				23,440	23,440	34	23440
35	V	23	Inservice Training & Education				900	900	35	900
36	V	24	Travel and Seminar				6,394	6,394	36	6394
37	V	25	Other Admin. Staff Transportation				0		37	
38	V	26	Insurance-Prop.Liab.Malpract				1,686	1,686	38	1686
39	Total			$			$ 266,784	$ * 266,784	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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Print Page 6

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15	
16	V	30	Depreciation				7,398	7,398	16	7398
17	V	31	Amortization of Pre-Op & Org				0		17	
18	V	32	Interest				(95)	(95)	18	-95
19	V	33	Real Estate Taxes				0		19	
20	V	34	Rent-Facility & Grounds				7,885	7,885	20	7885
21	V	35	Rent-Equipment & Vehicles				16,467	16,467	21	16467
22	V	36	Other				0		22	
23	V	38	Medically Nec Transportation				0		23	
24	V	39	Ancillary Service Centers				0		24	
25	V	40	Barber and Beauty Shops				0		25	
26	V	41	Coffee and Gift Shops				0		26	
27	V	42	Other				0		27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 31,655	$ * 31,655	39	

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	19	Adjustment for Related Organization	$ 275,520	0		$	$ (275,520)	15	-275520
16	V								16	
17	V	10a	Adjustment for Related Organization	217,471	Green Tree Pharmacy	100.00%	379,283	161,812	17	161812
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 492,991			$ 379,283	$ * (113,708)	39	

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6E

Print Previe

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6F

Print Previe

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6G

Print Previe

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6H

Print Previe

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6I

Print Previe

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Board	Management	25.98%	28,335	10	0.20	Directors Fee	$ 1,422	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Treas	Management	10.15%	28,334	10	0.20	Directors Fees	1,421	line 18, col 7	2
3	Craig Hart	Secretary/Treasurer	Management	20.00%	28,334	10	0.20	Directors Fees	1,421	line 18, col 7	3
4	Joe Warner	President	Management	2.50%	0	10	0.20	Directors Fees	2	line 18, col 7	
5	Bill Froelich	Chairman of Board	Management	25.98%	100,916	10	0.20	Salary	5,054	line 17, col 7	4
6	Tom Jefferson	Asst Secretary/Treas	Management	10.15%	99,277	10	0.20	Salary	4,973	line 17, col 7	5
7	Craig Hart	Secretary/Treasurer	Management	20.00%	83,881	10	0.20	Salary	4,202	line 17, col 7	6
8	Joe Warner	President	Management	2.50%	112,944	48	0.95	Salary	5,657	line 17, col 7	7
9	Bob Dickson	Executive Vice Presid	Management	0.80%	61,471	50	1.00	Salary	3,080	line 17, col 7	8
10	Cheryl Lowney	Executive Vice Presid	Management	0.31%	51,642	50	1.00	Salary	2,588	line 17, col 7	9
11	Steve Wannemacher	Executive Vice Presid	Management	0.26%	49,986	50	1.00	Salary	2,505	line 17, col 7	10
12	Connie Hoselton	Sr Vice President	Management	0.17%	34,343	40	1.00	Salary	1,721	line 17, col 7	11
13	Craig Ater	Sr Vice President	Management	0.21%	42,392	50	1.00	Salary	2,124	line 17, col 7	12
13								TOTAL	$ 36,170		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8] [Show Pgs 8E thru 8] [Hide Pgs 8A thru 8]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	BEDS	2,328	23	$ 71,961	$ 71,961	111	$ 3,431	1
2	2	Food Purchase	BEDS	2,328	23	0	0	111	0	2
3	3	Housekeeping	BEDS	2,328	23	0	0	111	0	3
4	4	Laundry	BEDS	2,328	23	0	0	111	0	4
5	5	Heat & Other Utilities	BEDS	2,328	23	29,301	0	111	1,397	5
6	6	Maintenance	BEDS	2,328	23	230,824	54,124	111	11,006	6
7	7	Other	BEDS	2,328	23	0	0	111	0	7
8	9	Medical Director	BEDS	2,328	23	0	0	111	0	8
9	10	Nursing & Medical Records	BEDS	2,328	23	0	0	111	0	9
10	11	Activities	BEDS	2,328	23	0	0	111	0	10
11	12	Social Service	BEDS	2,328	23	0	0	111	0	11
12	13	Nurse Aide Training	BEDS	2,328	23	43,025	0	111	2,051	12
13	14	Program Transportation	BEDS	2,328	23	0	0	111	0	13
14	15	Other	BEDS	2,328	23	0	0	111	0	14
15	17	Administrative	BEDS	2,328	23	637,854	637,854	111	30,413	15
16	18	Directors Fees	BEDS	2,328	23	99,885	0	111	4,763	16
17	19	Professional Services	BEDS	2,328	23	244,928	0	111	11,678	17
18	20	Fees, Subscription, Promotions	BEDS	2,328	23	94,145	0	111	4,489	18
19	21	Clerical & General Office Expense	BEDS	2,328	23	3,463,403	3,114,857	111	165,136	19
20	22	Employee Benefits & Payroll Taxe	BEDS	2,328	23	491,614	0	111	23,440	20
21	23	Inservice Training & Education	BEDS	2,328	23	18,866	0	111	900	21
22	24	Travel and Seminar	BEDS	2,328	23	134,093	0	111	6,394	22
23	25	Other Admin. Staff Transportatio	BEDS	2,328	23	0	0	111	0	23
24	26	Insurance-Prop.Liab.Malpract	BEDS	2,328	23	35,366	0	111	1,686	24
25	TOTALS					$ 5,595,265	$ 3,878,796		$ 266,784	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,328	23	$ 0	$ 0	111	$ 0	1
2	30	Depreciation	BEDS	2,328	23	155,150	0	111	7,398	2
3	31	Amortization of Pre-Op & Org	BEDS	2,328	23	0	0	111	0	3
4	32	Interest	BEDS	2,328	23	(1,990)	0	111	(95)	4
5	33	Real Estate Taxes	BEDS	2,328	23	0	0	111	0	5
6	34	Rent-Facility & Grounds	BEDS	2,328	23	165,362	0	111	7,885	6
7	35	Rent-Equipment & Vehicles	BEDS	2,328	23	345,363	0	111	16,467	7
8	36	Other	BEDS	2,328	23	0	0	111	0	8
9	38	Medically Nec Transportation	BEDS	2,328	23	0	0	111	0	9
10	39	Ancillary Service Centers	BEDS	2,328	23	0	0	111	0	10
11	40	Barber and Beauty Shops	BEDS	2,328	23	0	0	111	0	11
12	41	Coffee and Gift Shops	BEDS	2,328	23	0	0	111	0	12
13	42	Other	BEDS	2,328	23	0	0	111	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 663,885	$		$ 31,655	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle National Bank		XX	Mortage	4,640 plus Inter	01/15/99	$ 2,433,749	$ 2,185,903	01/15/06	variable	$ 178,865	1
2	LaSalle Loan Amortization		XX	Mortgage							5,534	2
3	Central Office Allocation		XX	Interest Income							(95)	3
4												4
5												5
	Working Capital											
6												6
7											0	7
8												8
9	TOTAL Facility Related						$ 2,433,749	$ 2,185,903			$ 184,304	9
	B. Non-Facility Related*											
10	Interest Income										407	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 407	14
15	TOTALS (line 9+line14)						$ 2,433,749	$ 2,185,903			$ 183,897	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report

1. Real Estate Tax accrual used on 2000 report.	$ 61,734	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 59,978	2
3. Under or (over) accrual (line 2 minus line 1).	$ (1,756)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 62,977	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 61,221	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill t the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered comple and timely filed until this statement and the corresponding real estate tax bills are filed. If you have an

To Print this page only

Hold down
Control Key and hit r

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HERITAGE MANOR-BLOOMINGTON COUNTY MCLEAN

FACILITY IDPH LICENSE NUMBER 0038349

CONTACT PERSON REGARDING THIS REPORT CRAIG L. ATER

TELEPHONE (309)823-7135 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	432104227008	HERITAGE MANOR-BLOOMINC	$ 59,254	$ 59,254
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 59,254	$ 59,254

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES xx NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1963	$ 37,500	1
2	Nursing Home		1999	79,076	2
3	TOTALS			$ 116,576	3

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	82		1963		$ 560,548	$		$	$	$	4
5	24		1966		221,147						5
6	5		1999								6
7											7
8											8
	Improvement Type**										
9	1978 Improvements			1978	14,607						9
10	1979 Improvements			1979	95,460						10
11	1980 Improvements			1980	75,591						11
12	1981 Improvements			1981	11,544						12
13	1982 Improvements			1982	9,256						13
14	1983 Improvements			1983	13,130						14
15	1984 Improvements			1984	7,215						15
16	1985 Improvements			1985	45,885						16
17	1986 Improvements			1986	13,469						17
18	1988 Improvements			1988	83,109						18
19	1989 Improvements			1989	2,439						19
20	1990 Improvements			1990	30,676						20
21	1991 Improvements			1991	4,207						21
22	1992 Improvements			1992	1,208						22
23	1993 Improvements			1993	97,303						23
24	1994 Improvements			1994	29,638						24
25	1995 Improvements			1995	121,304						25
26	BOILER			1996	17,850						26
27	EXHAUST HOOD			1996	1,075						27
28	CODE ALERT			1996	1,852						28
29	PHONE SYSTEM			1996	2,339						29
30	INTERIOR REMODEL			1996	103,103						30
31											31
32											32
33											33
34	C/O Allocation							7,398	7,398		34
35	Book Depreciation					107,916		108,056	140	1,362,266	35
36											36

* Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for Total

**Improvement type must be detailed in order for the cost report to be considered complete.

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Interior Rehab--paint, wallpaper, remodel facility	1997	211,945						37
38	Remodel Physical Therapy	1997	43,069						38
39	Disposal Unit--Kitchen	1997	1,439						39
40	Code Alert System	1997	1,997						40
41	Kitchen Remodel	1997	766						41
42									42
43	Code Alert/Nurse Call System	1998	3,654						43
44	Kitchen Remodel	1998	4,166						44
45	Remodel Physical Therapy	1998	1,813						45
46	Addition--Materials	1998	13,431						46
47	Addition--Professional Fees	1998	109,885						47
48									48
49	Addition--Materials	1999	1,155,066						49
50	Addition--Professional Fees	1999	22,035						50
51	Steam Table Hood	1999	3,821						51
52	ALTA Survey	1999	2,434						52
53	Dish Washing Area	1999	4,083						53
54	Sewage Pump	1999	2,492						54
55	Parking Lot Pavement	1999	6,743						55
56									56
57	Dayroom Light Fixtures	2000	6,189						57
58	Door Kickplates	2000	2,991						58
59	Storm windows	2000	4,011						59
60	Addition--Materials	2000	12,770						60
61	Addition--Professional Fees	2000	5,893						61
62	Roof Repair	2000	5,510						62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,190,158	$ 107,916		$ 115,454	$ 7,538	$ 1,362,266	70

**Improvement type must be detailed in order for the cost report to be considered complete.

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,190,158	$ 107,916		$ 115,454	$ 7,538	$ 1,362,266	1
2	Paging System	2001	2,456						2
3	Alarm Door/Lock	2001	1,950						3
4	Code Alert	2001	3,965						4
5	Electrical Wiring for A/C Unit	2001	1,805						5
6	Main Water Meter	2001	2,000						6
7	Valves Boiler Unit	2001	1,883						7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,204,217	$ 107,916		$ 115,454	$ 7,538	$ 1,362,266	34

**Improvement type must be detailed in order for the cost report to be considered complete.

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,204,217	$ 107,916		$ 115,454	$ 7,538	$ 1,362,266	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,204,217	$ 107,916		$ 115,454	$ 7,538	$ 1,362,266	34

**Improvement type must be detailed in order for the cost report to be considered complete.

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STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,204,217	$ 107,916		$ 115,454	$ 7,538	$ 1,362,266	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,204,217	$ 107,916		$ 115,454	$ 7,538	$ 1,362,266	34

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

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	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,204,217	$ 107,916		$ 115,454	$ 7,538	$ ########	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,204,217	$ 107,916		$ 115,454	$ 7,538	$ ########	34

****Improvement type must be detailed in order for the cost report to be considered complete.**

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,204,217	$ 107,916		$ 115,454	$ 7,538	$ ########	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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11									11
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,204,217	$ 107,916		$ 115,454	$ 7,538	$ ########	34

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 951,745	$ 73,907	$ 73,090	$ (817)		$ 754,447	71
72	Current Year Purchases	35,702						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 987,447	$ 73,907	$ 73,090	$ (817)		$ 754,447	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,308,240	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 181,823	82
83	Straight Line Depreciation	(line 70, col.7 + line 75 ,col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 188,544	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,721	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,116,713	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 18,914 Description: Copier, Cell Phone and Central Office Allocation
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		900		900
3	Classroom Wages (a)		13,304		13,304
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 14,204	$	$ 14,204
10	SUM OF line 9, col. 1 and 2 (e)	$ 14,204			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$		$ 66,858	$		$ 66,858	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			9,477			9,477	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			100,382	467		100,849	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				379,524		379,524	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39/3				4,722			4,722	13
14	TOTAL			$		$ 181,439	$ 379,991		$ 561,430	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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pt adj -21446
st adj 5277
Ot adj -8014

drugs 161811

Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 400	$	1
2	Cash-Patient Deposits	9,298		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	469,171		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,495		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	568,841		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,061,205	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	116,576		13
14	Buildings, at Historical Cost	3,146,294		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	958,208		16
17	Accumulated Depreciation (book methods)	(1,448,734)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	22,135		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,794,479	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,855,684	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 64,515	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,298		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	184,689		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,916		31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,977		32
33	Accrued Interest Payable	2,401		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 330,796	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,185,903		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,185,903	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,516,699	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,338,985	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,855,684	$	48

***(See instructions.)**

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,165,872	1
2	Restatements (describe):		2
3	**audit Adjustment**	0	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,165,872	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	173,113	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 173,113	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,338,985	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,437,449	1
2	Discounts and Allowances for all Levels	(603,045)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,834,404	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	303,811	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 303,811	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	27,773	11
12	Gift and Coffee Shop	1,135	12
13	Barber and Beauty Care	24,593	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	5,600	16
17	Sale of Drugs	375,285	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	13,460	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 447,846	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***	407	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 407	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		0	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,586,468	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 907,855	31
32	Health Care	2,073,745	32
33	General Administration	984,331	33
	B. Capital Expense		
34	Ownership	431,201	34
	C. Ancillary Expense		
35	Special Cost Centers	16,223	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,413,355	40
41	**Income before Income Taxes (line 30 minus line 40)****	173,113	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 173,113	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,904	2,072	$ 49,045	$ 23.67	1
2	Assistant Director of Nursing	1,896	2,072	38,566	18.61	2
3	Registered Nurses	10,188	10,838	197,290	18.20	3
4	Licensed Practical Nurses	23,553	26,190	437,603	16.71	4
5	Nurse Aides & Orderlies	67,088	70,230	697,052	9.93	5
6	Nurse Aide Trainees	810	810	13,304	16.42	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,424	1,625	28,298	17.41	8
9	Activity Director					9
10	Activity Assistants	5,958	6,679	61,494	9.21	10
11	Social Service Workers	2,106	2,138	27,988	13.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,520	13,563	245,762	18.12	15
16	Dishwashers					16
17	Maintenance Workers	10,439	11,054	111,061	10.05	17
18	Housekeepers	8,115	8,741	66,314	7.59	18
19	Laundry	5,666	6,256	50,862	8.13	19
20	Administrator	2,080	2,080	58,397	28.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,950	8,719	107,580	12.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	161,697	173,067	$ 2,190,616 *	$ 12.66	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		12,000		36
37	Medical Records Consultant		500		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,982		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,305		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 17,787		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ben Hart	Administrator		$ 58,397
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,397

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 275,520
All Legal is adjusted to zero	Legal	3,068
SMS , Inc.	Reimbursement	9,408
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 287,996

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,547
Unemployment Compensation Insurance	8,832
FICA Taxes	167,582
Employee Health Insurance	110,185
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	17,080
Employee Benefits - central office	23,440
TOTAL (agree to Schedule V, line 22, col.8)	$ 391,666

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	6,023
Health Care Worker Background Check	
(Indicate # of checks performed)	567
Central Office Allocation	4,489
Promotional Advertising	5,843
Public Relations	6,966
Dues and Subscriptions	6,359
License and Fees	655
Less: Public Relations Expense	(6,966)
Non-allowable advertising	(528)
Yellow page advertising	(5,843)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,965

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	941
	88
Seminar Expense	3,767
Non Allowable	(9,191)
Central Office Allocation	6,394
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number HERITAGE MANOR-BLOOMINGTON # 0038349 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? _____
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **yes** If YES, have these costs
been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **no** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **5,000** Line _____

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? _____
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES _____ NO **xx** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **60,773**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **no** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **yes** Indicate the amount. $ **1,176**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? _____ If YES, please indicate the amount of income earned from such a
program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? _____
g. Does the facility transport residents to and from day training? _____
Indicate the amount of income earned from providing such
transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? _____
Firm Name: **Sulaski & Webb** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **no** If no, please explain. **Not complete as of the filing date.**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount				
1009			PETTY CASH	400							1009	1009 PETTY CAS	400
1010			CASH IN BANK								1100	1100 ACCTS REC	73,347
1040			CASH IN BANK-PAYROLL								1101	1101 ALLOW. FC	(20,301)
1100			ACCOUNTS RECEIVABLE	469171							1110	1110 ACCTS REC	77,001
1110			MEDICARE RECEIVABLES								1125	1125 ACCTS REC	314,095
1125			IPA INCOME RECEIVABLE								1135	1135 ACCTS REC	25,029
1130			MEDICARE COST REPORT								1140	1140 UNAPPLIEI	0
1135			ACCOUNTS RECEIVABLE-IC								1145	1145 A/R SUSPEI	0
1140			UNAPPLIED CASH RECEIPTS								1200	1200 PREPAID I	0
1145			A/R SUSPENSE-REFUNDS								1220	1220 OTHER PRI	0
1190			ACCRUED INTEREST REC								1300	1300 DIETARY I	4,250
1200			PREPAID INSURANCE	13495							1310	1310 SUPPLIES I	4,000
1220			OTHER PREPAID EXPENSES								1320	1320 LINEN INV	5,245
1300			FOOD INVENTORY								1409	1409 LAND	116,576
1310			SUPPLIES INVENTORY								1450	1450 FURNITUR	958,208
1409			LAND	116576							1460		-723891
1450			FURNITURE & EQUIPMENT	958208							1475	1475 CODE ALEI	3,146,294
1460			ACCUM DEPR-FURN & EQUIP	-723891							1490	1490 ACCUM DE	(724,843)
1475			BUILDING & IMPROVEMENTS	3146294							1530	1530 RESIDENT	9,298
1490			ACCUM DEPR-BUILDING	-724843							1550	1550 LOAN FEES	22,135
1530			RESIDENT FUNDS	9298							1551	1551 LOAN FEES	0
1550			LOAN FEES	22135							1850	1850 INTERCOM	568,841
1560			REAL ESTATE TAX ESCROW								2010	2010 ACCOUNTS	(64,515)
1575			REIMBURSABLE PURCHASES								2100	2095 BONUSES I	0
1850			INTRACOMPANY	568841							2100	2100 ACCRUED	-63436
2010			ACCOUNTS PAYABLE	-64515							2100	2100 PR CLEARI	0
2095			BONUSES PAYABLE								2100	2100 PR CLEARI	0
2100			ACCRUED PAYROLL	-63436							2110	2110 ACCRUED	-121253
2110			ACCRUED VACATION PAY	-121253							2120	2120 U.C. TAXES	-1752
2120			UC TAXES PAYABLE								2125	2125 FICA TAXE	0
2125			FICA TAX PAYABLE	-6916	-6916						2130	2130 FEDERAL V	0
2130			FIT PAYABLE								2140	2140 STATE W/H	-2098
2140			STATE W/H PAYABLE		0						2152	2152 WORKERS	-2663
2145			EARNED INCOME CREDIT								2225	2225 EMPLOYEE	0
2150			UC FED CREDIT REDUCTION								2230	2230 PAYROLL S	0
2230			PAYROLL SAVINGS								2235	2240 UNITED FU	9
2235			IRA W/HOLDINGS								2240	2246 GROUP INS	0
2240			UNITED WAY								2246	2250 401K W/H	0
2245			GROUP INSURANCE PAYABLE								2250		
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2260	2260 WAGE GAF	-412
2260			WAGE GARNISHMENTS								2300	2300 ACCRUED	(2,401)
2280			MISC PAYROLL DEDUCTIONS								2320	2320 IPA PAYME	0
2300			ACCRUED INTEREST PAYABLE	-2401							2350	2350 REAL ESTA	-62977
2310			SALES TAX PAYABLE								2385		
2320			IPA PAYMENTS PAYABLE	0							2400	2400 CURRENT I	(120,000)
2350			REAL ESTATE TAX PAYABLE	-62977							2512	2512 DUE TO RE	(9,298)
2385			ACTIVITY FUND	0							2600	2600 LASALLE E	(1,287,725)
2390			SECURITY DEPOSITS								2600		
2391			VOLUNTEER FUND								2625	2625 LASALLE C	(898,178)
2393			HEART FUND/BAZAAR								2625		
2395			DEFERRED INC EMP & MEM								2695	2695 CURRENT I	120000
2400			CURRENT PORTION LT DEBT								2720	2720 RETAINED	-1165872
2460			INCOME TAXES PAYABLE									net income	-173113
2512			DUE TO RESIDENTS	-9298									0
2600			MORTGAGE PAYABLE	-2185903									
2650			EQUIPMENT LOAN PAYABLE									balance	0
2695			CURRENT PORTION LT DEBT										
2696			DEFERRED INCOME TAXES										
2710			COMMON STOCK										
2720			RETAINED EARNINGS	-1165872									
2970			PROFIT/LOSS FOR PERIOD	-173113									
3007.1			PATIENT DAYS-PRIVATE	12733							3007	3007 PATIENT D	12,733
3007.2			PATIENT DAYS-IPA	22996							3007	3007 PATIENT D	22,996
3007.3			PATIENT DAYS-MEDICARE	2469							3007	3007 PATIENT D	2,469
3007.4			PATIENT DAYS-CONVERSION								3007		
3007.5			PATIENT DAYS-LICENSED								3007		
3007.6			PATIENT DAYS-TOTAL								3007		
3010		1	BASIC CHARGE-PRIVATE & VA	-1441596		0	0	0	0		3007		
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0		3010	3010 BASIC CHA	-1441596
3020		1	BASIC CHARGE-IPA	-2042351		0	0	0	0		3020	3020 BASIC CHA	(2,042,351)
3030		1	BASIC CHARGE-MEDICARE	-689880		0	0	0	0		3030	3030 BASIC CHA	(689,880)
3035		4	DAY CARE/HOME CARE			0	0	0	0		3040	3040 LIGHT NUF	-1619
3040		1	LIGHT NURSING CARE	-101837		0	0	0	0		3050	3050 MEDIUM N	(47,722)
3050		1	MEDIUM NURSING CARE			0	0	0	0		3060	3060 HEAVY NU	(10,637)
3060		1	HEAVY NURSING CARE			0	0	0	0		3061	3061 SKILLED N	(41,859)
3061		1	SKILLED NURSING CARE								3080	3080 NURSNG SI	(41,282)
3080		1	NURSING SUPPLIES-PRIVATE	-161766		0	0	0	0		3081	3081 NURSNG SI	(73,200)
3081		1	NURSING SUPPLIES-IPA			0	0	0	0		3082	3082 NURSNG SI	(16,111)
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0		3083	3083 NURSNG SI	(31,173)
3083		1	NURSING SUPPLIES MED PT B								3100	3100 DRUGS-ME	(150,185)
3100		17	DRUGS	-375285		0	0	0	0		3101	3101 DRUGS-OT	(225,100)
3101		17	DRUGS-OTHER								3110	3110 PHYSICAL	(22,173)
3110		6	PT-PRIVATE	-303811		0	0	0	0		3111	3111 PHYSICAL	(600)
3111		6	PT-IPA			0	0	0	0		3112	3112 PHYSICAL	-132352
3112		6	PT-MEDICARE PART A			0	0	0	0		3113	3113 PHYSICAL	(26,074)
3113		6	PT-MEDICARE PART B			0	0	0	0		3140	3140 LABORATC	(6,276)
3130		1	PUBLIC AID ASSESSMENT INC								3150	3150 ST/OT-PRIV	-17728
3140		19	LABORATORY INCOME			0	0	0	0		3151	3151 ST/OT-IPA	0
3150		6	SPEECH/OT-PRIVATE			0	0	0	0		3152	3152 ST/OT-M/C	(95,840)
3151		6	SPEECH/OT-IPA			0	0	0	0		3153	3153 ST/OT-M/C	-2768
3152		6	SPEECH/OT-MED PART A			0	0	0	0		3160	3160 X-RAY SER	0
3153		6	SPEECH/OT MED PART B								3410	3410 IPA/OTHER	181,416
3410		2	IPA DISCOUNTS	603045		0	0	0	0		3411	3411 MEDICARE	21664
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0		3420	3420 MEDICARE	399,965
3420		2	MEDICARE DISCOUNTS			0	0	0	0		3500	3440 IPA ASSESS	0
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0		3520	3520 RENT INCO	-5600
3520		16	RENT INCOME	-5600		6	0	6	-5600		3530	3530 BEAUTY SI	(24,593)
3530		13	BEAUTY SHOP	-24593		0	0	0	0		3560	3560 ACTIVITY I	-586
3560		12	ACTIVITY FUND INCOME	-586		0	0	0	0		3570	3570 VENDING I	-549
3570		12	VENDING INCOME/EXPENSE	-549		0	0	0	0		3590	3580 RES. PERSC	-19
3580		12	MANAGEMENT FEES			0	0	0	0		3595	3590 EQUIPMEN	-13460
3590		1	EQUIPMENT RENTAL	-19		0	0	0	0		3600	3595 RESIDENT	0
3595		21	RESIDENT TRANSPORTATION	-13460		0	0	0	0		4110	4110 G&A WAGI	102094
3600		21	MISC INCOME	0		0	0	0	0		4111	4111 ADMINISTI	58,397
4110			GENERAL & ADMINIST WAGES	102094	107580	21	1	17	0		4115	4115 G&A PTO &	5486
4111			ADMINISTRATOR WAGES	58397	58397	17	1	0	0		4120	4120 EMPLOYEI	16069
4115			VACATION & SICK - G&A	5486		21	1	0	0		4125	4125 EMPLOYEI	0
4120	4475		EMPLOYEE BENEFITS	16418	368226	22	3	0	0		4130	4130 EMPLOYEI	662
4125			EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0		4135	4135 EMPLOYEI	0
4130			EMPLOYEE SCHOLORSHIP WAGE	662		21	1	0	0		4250	4250 OFFICE SUI	10403
4135			EMPLOYEE SCHOLORSHIP COST	0		23	3	0	0		4255	4255 POSTAGE	2,929
4220			DIRECTORS FEES			18	3	0	0		4260	4260 TELEPHON	8,857
4250	4255		OFFICE SUPPLIES	14172	14220	21	2	0	0		4275	4275 TRAINING	728
4260			TELEPHONE	8857	8857	21	3	0	0		4276	4276 INJURY PR	977
4275			TRAINING & EMPLOYEE DEVL	728	728	23	3	16	0		4280	4280 GENERAL T	941
4280			GENERAL TRAVEL	941	4796	24	3	16	0		4281	4281 MEAL EXP	88
4281			MEAL EXPENSE FOR TRAVEL	88		24	3	19	0		4285	4285 EDUCATIO	3740
4285			EDUCATION & SEMINAR	3767		24	3	19	-9191 ***		4289	4289 MEETINGS	27
4290			HELP WANTED ADVERTISING	6023	87586	20	3	0	0	-60773	4290	4290 HELP WAN	6,023
4291			PROMOTIONAL ADVERTISING	5843		20	3	25	-5843		4291	4291 PROMOTIO	5,843
4292			PUBLIC RELATIONS	6966		20	3	25	-6966		4292	4292 PUBLIC RE	6,966
4300			LICENSES & FEES	61828		20	3	17	0		4300	4300 LICENSE &	61,828
4310			DUES & SUBSCRIPTIONS	6359		20	3	17	-528		4310	4310 DUES & SU	6359
4320			CONTRIBUTIONS	65		27	3	20	-65		4320	4320 CONTRIBU	65
4350			PROFESSIONAL FEES	12476	287996	19	3	22	-3068		4350	4350 PROFESSIC	12476
4355			MEDICAL DIRECTOR	12000	12000	9	3	0	0		4355	4355 MEDICAL I	12000
4360			UTILIZATION REVIEW			10	3	0	0		4362	4362 MEDICAL I	500
4361			OTHER PHYSICIAN FEES			39	3	0	0		4363	4363 PHARMACI	2982
4362			MEDICAL RECORDS CONSULT	500		10	3	0	0		4364	4364 SOCIAL SE	2,305
4363			PHARMACIST FEES	2982		10	3	0	0		4370	4370 TV RENTAI	1,311
4364			SOC SERV/ACT CONSULT	2305	2305	12	3	0	0		4383	4383 BACKGROI	567
4370			TV RENTAL	1311		35	3	5	-1311		4390	4390 OTHER TA:	0
4380			INCOME TAXES		19517	27	3	26	0		4400	4400 PAYROLL T	170,964
4383			BACKGROUND CHECKS	567		20	3	26	0		4401	4401 PAYROLL T	5450
4400			PAYROLL TAXES	170964		22	3	0	0		4410	4410 GROUP INS	110,185
4401			PAYROLL TAXES ADMINIST	5450		22	3	0	0		4420	4420 LIABILITY	26,428
4410			GROUP INSURANCE	110185		22	3	0	0		4430	4430 WORKMAN	54460
4420			LIABILITY INSURANCE	26428	26428	26	3	0	0		4435	4435 W/C-FIRST	7273
4425			INSURANCE-OWNERS			22	3	21	0		4436	4436 DRUG TEST	1837
4430			WORKMENS COMP INSURANCE	64547		22	3	0	0		4450	4450 CENTRAL (	275,520
4450			CENTRAL OFFICE FEES	275520		19	3	34	-275520		4460	4460 BAD DEBT	14,000
4460			BAD DEBTS	19452		27	3	24	-19452		4461	4461 BAD DEBT	5,452
4470			LOST ITEMS-RESIDENTS	0		27	3	0			4470	4470 LOST ITEM	0
4490			MISCELLANEOUS			27	3	0	0		4475	4475 UNIFORM I	349
4510			REAL ESTATE TAXES	61221	61221	33	3	0	0		4486	4486 SERVICE C	6,288
4600			LEASED EQUIPMENT	2447	3758	35	3	16	0		4490	4490 MISC EXPE	(1,327)
5110			MAINTENANCE SALARIES	103813	111061	6	1	0	0		4496	4496 MISC. M.I.S	840
5120			MAINTENANCE SICK & VAC	7248		6	1	0	0		4510	4510 REAL ESTA	61,221
5130			ELECTRIC	43469	106960	5	3	0	0		4600	4600 LEASED EC	2,447
5131			NATURAL GAS	46394		5	3	0	0		5110	5110 MAINTENA	103,813
5132			HEATING & DEISEL OIL			5	3	0	0		5120	5120 MAINTENA	7,248
5133			WATER & SEWER	17097		5	3	0	0		5130	5130 ELECTRIC	43469
5134			TRASH COLLECTION	8787	48183	6	3	0	0		5131	5131 NATURAL	46,394
5140			PROPERTY PLANT REPLACEMNT	9343	46669	6	2	0	0		5133	5133 WATER & S	17,097
5160			GENERAL REPAIR & MAINT	37326		6	2	0	0		5134	5134 TRASH COI	8,787
5165			MAINTENANCE CONTRACTS	39396		6	3	0	0		5140	5140 PROP/PLAN	9343
5210			DIETARY WAGES	230064	245762	1	1	0	0		5160	5160 GENERAL I	37,326
5220			DIETARY SICK & VAC	15698		1	1	0	0		5165	5165 MAINTENA	33,108
5240			SALES TAX			2	3	13	-857		5210	5210 DIETARY V	230,064
5248			FOOD PURCHASES	171313	170137	2	2	0	0		5220	5220 DIETARY F	15698
5250			SUPPLIES-DISHWASHING	4995	22966	1	2	0	0		5248	5248 FOOD PURC	172,640
5260			DIETARY REPLACEMENT	1964		1	2	0	0		5250	5250 SUPPLIES I	4,995
5270			KITCHEN SUPPLIES-PAPER	16007		1	2	0	0		5260	5260 REPLACEM	1,964
5295			MEAL CREDIT	-1176		2	2	0	0		5270	5270 KITCHEN S	16,007
5310			LAUNDRY WAGES	47654	50862	4	1	0	0		5295	5295 MEAL INCC	(1,176)
5340			LAUNDRY SICK & VAC	3208		4	1	0	0		5310	5310 LAUNDRY	47,654
5370			LAUNDRY REPLACEMENT	9131	15555	4	2	0	0		5340	5340 LAUNDRY	3,208
5380			LAUNDRY REIMBURSEMENT			4	3	0	0		5370	5370 REPLACEM	9,131
5390			LAUNDRY SUPPLIES	6,424		4	2	0	0		5380	5380 OUTSIDE L	45
5410			HOUSEKEEPING WAGES	62251	66314	3	1	0	0		5390	5390 SUPPLIES	6,379
5440			HOUSEKEEPING SICK & VAC	4063		3	1	0	0		5410	5410 HOUSEKEE	62,251
5480			HOUSEKEEPING SUPPLIES	7965	23386	3	2	0	0		5440	5440 HOUSEKEE	4063
5490			HOUSEKEEPING SUPPLIES-PPR	15421		3	2	0	0		5480	5480 SUPPLIES-(	7,965
6010			RN WAGES-MEDICARE		1447854	10	1	0	0		5490	5490 SUPPLIES-I	15,421
6020			RN WAGES-NON MEDICARE	185884		10	1	0	0		6020	6020 RN WAGES	185884
6030			DON WAGES	49045		10	1	0	0		6030	6030 DON WAGI	49045
6035			ADON	38566		10	1	0	0		6035	6035 ADON WAC	38,566
6040			RN SICK & VACATION	11406		10	1	0	0		6040	6040 RN PTO & I	11,406
6110			LPN WAGES-MEDICARE			10	1	0	0		6120	6120 LPN WAGE	403,650
6120			LPN WAGES-NON MEDICARE	403650		10	1	0	0		6140	6140 LPN PTO &	33,953
6130			LPN WAGES OTHER			10	1	0	0		6220	6220 AIDES WAC	645,392
6140			LPN SICK & VACATION	33953		10	1	0	0		6240	6240 AIDES PTO	51,660
6210			AIDE WAGES-MEDICARE			10	1	0	0		6245	6245 CONTRACT	0
6220			AIDE WAGES-NON MEDICARE	645392		10	1	0	0		6246	6246 CONTRACT	0
6230			WARD CLERKS			10	1	0	0		6247	6247 CONTRACT	0
6240			AIDE VACATION & SICK	51660		10	1	0	0		6250	6250 NURSE AID	13,304
6245			CONTRACT NURSES-RN	0		10	3	0	0		6255	6255 NURSE AID	900
6246			CONTRACT NURSES-LPN	0		10	3	0	0		6260	6260 NURSE AID	(27,773)
6247			CONTRACT NURSES-AIDES	0		10	3	0	0		6270	6270 REHAB WA	26,300
6250			NURSE AIDE TRAINING WAGES	13304	13304	13	1	0	0		6275	6275 REHAB PTC	1,998
6255			NURSE AID TRAINING EXP	900	900	13	2	0	0		6290	6290 NURSING S	60413
6260			NURSE AIDE TRAINING REIMB	-27773		0	0	0	0		6295	6295 NURSING S	5,822
6270			REHAB WAGES	26300		10	1	0	0		6390	6390 REPLACEM	4,793
6275			REHAB SICK & VAC	1998		10	1	0	0		6490	6490 OTHER	7,914
6280			NURSING DEPT EDUCATION			23	3	0	0		7280	7280 DRUG PUR	93,021
6290			NURSING SUPPLIES	60413	71028	10	2	0	0		7281	7281 DRUG PUR	124692
6295			NURSING SUPPLIES	5822		10	2	0	0		7380	7380 LABORATC	4,371
6390			REPLACEMENT-NURSING	4793		10	2	0	0		7391	7391 AMBULAN	0
6490			NURSING OTHER	7914	11396	10	3	0	0		7393	7393 OTHER A S	351
7280			DRUG PURCHASES	93021	218180	39	2	0	161811 ***		7510	7510 ACTIVITIE	56022
7281			DRUG PURCHASES-OTHER	124692		39	2				7540	7540 ACTIVITIE	5,472
7380			LABORATORY SERVICES	4,722	205,622	39	3	0	0		7590	7590 ACTIVITIE	1670
7410			HOME HEALTH SALARY			39	1	0	0		7620	7620 PHYSICAL	121,828
7440			HOME HEALTH SICK & VAC			39	1	0	0		7660	7660 P.T. SUPPL'	467
7450			HOME HEALTH EXPENSES			39	3	0	0		7710	7710 SOCIAL SE	26410
7510			ACTIVITES WAGES	56022	61494	11	1	0	0		7720	7720 SOCIAL SE	1578
7540			ACTIVITIES SICK & VAC	5472		11	1	0	0		7730	7730 SOCIAL SE	4
7590			ACTIVITIES SUPPLIES	1670	1670	11	2	0	0		7740	7740 OCCUPATI	74872
7595			ACTIVITIES FEES	0	0	11	3	0	0		7750	7750 SOCIAL TH	0
7610			PT WAGES			39	1	0	0		7770	7770 SPEECH TH	4,200
7611			PT SICK & VACATION			39	1	0	0		7820	7820 BEAUTICIA	16,223
7620			PT FEES	121828		39	3	0	-21446 ***		7890	7890 BEAUTY SI	0
7660			PT SUPPLIES	467		39	2	0	0		7960	7960 VOLUNTEE	48
7710			SOCIAL SERVICE WAGES	26410	27988	12	1	0	0		8120	8120 INTEREST	149,467
7720			SOCIAL SERVICE SICK & VAC	1578		12	1	0	0		8125	8125 ALLOCATE	29,398
7730			SOCIAL SERVICE EXPENSES	4	4	12	2	0	0		8130	8130 DEPRECIA	181,823
7740			OT FEE	74872		39	3	0	-8014 ***		8150	8150 LOAN FEE	5,534
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0		9510		(407)
7770			SPEECH THERAPY FEE	4200		39	3	0	5277 ***		9520		
7800			BEAUTICIAN WAGES		0	40	1	0	0		9530		
7810			BEAUTICIAN SICK & VAC			40	1	0	0				
7820			BEAUTICIAN FEES	16223	16223	40	3	0	0				(173,113)
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0				
7910			VOLUNTEER COORDINATOR			21	1	0	0				
7940			VOL COORD SICK & VAC			21	1	0	0				
7960			VOL COORD SUPPLIES	48		21	2	0	0				
8100			RENT		0	34	3	0	0				
8120			INTEREST EXPENSE	178865	184399	32	3	14	-407				
8130			DEPRECIATION	181823	181823	30	3	9	-677				
8150			LOAN FEE AMORTIZATION	5534		32	3	0	0	60773			
9510			INTEREST INCOME	-407		32	0	10	0				
9520			MISC NON-OPERATING INCOME	0		0	0	0	0				
9700			INCOME TAXES	0		0	0	0	0				
				4385175	4413355								
					28180								
GRAND TOTALS				-173113					-191857				
				(NET INCOME)									
				0									

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0
173113